

ALAMEDA HOSPITAL  
MEDICAL STAFF

RULES AND REGULATIONS

November 29, 2018

**RULES AND REGULATIONS**  
**OF THE MEDICAL STAFF OF ALAMEDA HOSPITAL**  
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**RULES AND REGULATIONS  
OF THE MEDICAL STAFF  
AT ALAMEDA HOSPITAL**

**ARTICLE I - PREAMBLE**

All terms used in these Rules and Regulations shall have the same meaning as used in the Medical Staff Bylaws, unless otherwise herein defined.

**ARTICLE II - ADMISSION OF PATIENTS**

**2.1 General**

Each patient shall be under the general care and supervision of a member of the Medical Staff and shall be admitted to the department which has expertise in the treatment of the disease which necessitated admission.

**2.2 Provisional Diagnosis**

The admitting physician shall provide a provisional diagnosis prior to admission to the hospital.

**2.3 Discrimination**

No patient shall be denied admission to the hospital on the basis of race, color, creed, national origin, sex, sexual orientation, disability, or ability to pay.

**2.4 Infection Control**

In case of communicable diseases or suspected communicable disease, appropriate isolation and infection control procedures must be followed, and the Infection Control Coordinator must be notified.

**2.6 Admission Exceptions**

The Medical Staff shall admit patients except the following:

1. Admissions primarily for psychiatric treatment.
2. Patients who are dangerous to themselves or to others, who are destructive to property or who are offensive to other patients for psychiatric reasons unless underlying medical condition necessitates admission for stabilization and/or monitoring.
3. Patients requiring facilities not available in the hospital.
4. Medical patients under the age of fourteen (14) years.
5. Emergency surgical patients under the age of fourteen (14) years.

## **ARTICLE III- CONSENTS**

### **3.1 Conditions of Admission**

Unless an emergency exists Consent for Treatment/Conditions of Admission Form signed by the patient or the patient's surrogate decision-maker shall be obtained at the time of admission by appropriate hospital personnel. When due to unusual circumstances it is not obtained at such time, it should be obtained as soon as possible after admission.

### **3.2 Informed Consent Defined**

Informed consent is a process whereby the patient, or his or her surrogate decision-maker, is given information which will enable him or her to reach a meaningful, informed decision regarding whether to give consent for the complex treatment or procedure which is proposed.

**3.2-1** The information provided should include a description of:

- a. the nature of the recommended treatment;
- b. its expected benefits or effects;
- c. the associated risks and possible complications;
- d. any alternative procedures and their expected benefits or effects and associated risks and possible complications;
- e. any independent economic interests a physician may have which may influence his or her treatment recommendations; and
- f. risks of not performing the procedure.

### **3.3 Who May Give Informed Consent**

Consistent with any limitations or exceptions provided by law, before any patient undergoes surgery or any complex diagnostic or therapeutic procedure, the responsible practitioner shall obtain the patient's (or if the patient does not have decision-making capacity, the patient's surrogate decision-maker), informed consent to the surgery or procedure.

Discussion of the procedure shall be in lay terms, such that the patient is able to fully comprehend. The hospital shall make all reasonable efforts to provide interpreter services to its non-English speaking, limited English speaking, and deaf patients for informed consent discussions. Whenever the circumstances warrant less than a full informed consent, the practitioner shall fully document those circumstances in the progress notes.

### **3.4 Physician Documentation of Informed Consent**

**3.4-1** The physician member involved in securing informed consent shall document in the progress notes of the patient's medical record, their discussions regarding the proposed procedure and whether they secured informed consent.

**3.4-2** The documentation related to an emergency situation shall be entered in a progress note by the physician and must describe:

- a. the nature of the emergency;
- b. the reasons consent could not be secured from the patient or a surrogate decision- maker; and
- c. the necessity of treatment, including the probable result if treatment would

have been delayed or not provided.

### **3.5 Particular Legal Requirements**

Special consents must be obtained as required by law. Special consents shall be obtained where required for at least the following: blood transfusions; elective sterilization procedures; hysterectomies; use of investigational drugs or devices; participation in human experimentation; reuse of hemodialysis filters. Special consents for SNF patients must also be obtained, as required by law, for use of psychotropic medications, physical restraints and the prolonged use of a device that may lead to the inability to regain use of a normal bodily function. Special consent must be secured by a physician in the manner specified in the law applicable to these particular procedures. When appropriate, hospital personnel shall verify that appropriate special consent has been obtained. The laws related to special consents are described in the CHA Consent Manual.

**3.5-1** The attending physician, or designee, is responsible for seeing that consent for the special procedure is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

**3.5-2** Verification of Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures Consistent with any limitation or exceptions provided by law, appropriate hospital personnel shall secure the signature of the patient or the patient's surrogate decision-maker on the Verification of Authorization Form and Consent to Surgery or Special Diagnostic or Therapeutic Procedure Form, verifying that the patient's attending practitioner obtained the patient's or the patient's surrogate decision-maker's informed consent to surgery or complex diagnostic or therapeutic procedure.

## **ARTICLE IV - DEATHS**

### **4.1 Pronouncement of Death**

A physician shall pronounce the patient dead within a reasonable period of time. An authenticated entry of the pronouncement of death must be made in the patient's medical record prior to release of the patient's remains.

### **4.2 Death Certificate**

A death certificate and copy shall be prepared by the Admissions department for completion by the pathologist after the autopsy. If no autopsy is to be performed, the death certificate is completed by the Admissions department, signed by the physician last in attendance, and sent, via the electronic death record system (EDRS), to the Vital Statistics Department.

### **4.3 Autopsy**

If an autopsy is deemed appropriate, the pronouncing physician shall obtain permission for performance of an autopsy in accordance with the autopsy policy and procedure of the hospital. The persons who may consent to autopsies are identified by California law.

**4.3-1** Except in coroner's cases, all autopsies shall be performed by the hospital pathologist or his or her designee.

- 4.3-2** Data from the autopsy may be presented at a department meeting and reviewed as part of the Performance Improvement activities.

## **ARTICLE V - DISCHARGES OF PATIENTS**

### **5.1 Discharges and Transfers**

#### **5.1-1 Discharge Planning**

The Discharge Planning Policy (hospital and administrative policy) shall be followed for each patient.

- a. Discharge planning begins upon admission and is on-going throughout the patient's stay.
- b. All disciplines are responsible for documenting any discharge instructions provided to the patient, family and/or caregivers.
- c. On discharge, patient's condition and status of current patient problems are assessed and documented in the medical record.

#### **5.1-2 Transfers to Other Facilities**

- a. No patient shall be transferred or discharged for the purpose of affecting a transfer to another hospital unless arrangements have been made in advance for admission to such hospital and the person legally responsible for the patient has been notified or attempts have been made to notify such person. A transfer or discharge to affect transfer shall not be made if the option of the attending physicians is that such transfer or discharge would endanger the patient's health.

#### **5.1-3 Leaving Against Medical Advice (AMA)**

- a. AMA is defined as an inpatient or outpatient who demands to leave or be discharged from the hospital before the completion of treatment or contrary to the advice of the patient's physician.
- b. If a patient indicates that he or she will leave the hospital without a discharge order from the attending physician or designee, the nursing staff shall contact the patient's attending physician or designee to arrange for the patient to discuss his or her plan with the attending physician or designee before the patient leaves.
- c. The attending physician or designee shall discuss with the patient the implications of leaving the hospital against medical advice including the risks involved and the benefits of remaining for treatment, as necessary to meet the standard of informed refusal of treatment. The patient who insists on leaving against medical advice shall be asked to sign the form titled "Leaving the Hospital Against Medical Advice" in the presence of at least one witness. If the patient cannot be located or refuses to sign the form, the nursing staff who witnessed the refusal, shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

#### **5.1-4 Absent Without Leave (AWOL)/Elopement**

- a. A patient who leaves the hospital without notifying any healthcare worker prior to departure is considered AWOL.
- b. When it has been determined that a patient is AWOL, the immediate area shall be searched and the patient shall be paged overhead. The attending physician or designee will be notified.
- c. Documentation of the circumstances, time and date of the incident shall be documented by the nurse in the medical record.
- d. **Elopement (Emergency Department)**  
Any patient that has been seen by the Triage Registered Nurse, had a triage assessment initiated and/or been placed in a treatment area but left prior to completion of an evaluation by the Emergency Department provider is deemed to have eloped. The procedure for documentation is pursuant to the Emergency Department Policy and Procedure "Patient Elopement from the Emergency Department".

#### **5.1-5 Reporting**

An occurrence report shall be completed when a patient has left against medical advice or is considered to have left AWOL or has eloped. An attempt will be made to notify the patient of known or suspected medical conditions that warrant further follow-up. The contact or attempted contact with the patient will be documented in the progress notes.

### **ARTICLE VI - MEDICAL CARE OF PATIENTS**

#### **6.1 Medication Orders**

Drugs shall be ordered by a person lawfully authorized and credentialed to prescribe and shall conform with the United States Pharmacopeia or National Formulary, with the exception of drugs used in bona fide approved clinical investigations or newly approved medications that are not listed but have been approved by an appropriate hospital committee. Exceptions shall be approved by the Medical Executive Committee in accordance with all current applicable regulations.

#### **6.2 Review of Drug Orders/Automatic Stop Orders**

**6.2-1** Each physician is expected to review all medications for all patients regularly to ensure discontinuation of all orders that are no longer needed.

##### **6.2-2 Automatic Stop Orders**

For reasons of patient safety, certain categories of drugs will automatically be stopped at certain established times according to the hospital policy and procedure.

**6.2-3** The pharmacist shall notify the attending or ordering physician whenever an automatic stop order is to occur by placing a notice in the medical record at least 48 hours in advance of the pending Automatic Stop Order.

**6.2-4** An automatic stop order does not apply when the prescriber specifies the number of doses or an exact and reasonable period of time.

**6.2-5** Orders for drugs will automatically stop and any new or continuing drugs must be reordered when:

- a. a patient goes to surgery; or
- b. a patient's level of care is changed from:
  - outpatient setting to inpatient setting.
  - ICU to medical surgical unit, medical surgical unit to telemetry

### **6.3 Drugs and Medications Brought from Home**

All drugs and medications brought to the hospital by patients will be sent home with the patient's family whenever possible. For patients who bring their own medication, The Patient's Own Medications policy shall be followed.

### **6.4 Order Sets**

Order sets for any treatments may be used for a specific patient when authorized by a person licensed and credentialed to issue the specific orders. A copy of order sets for a specific patient must be dated, promptly authenticated, and included in the patient's medical record.

These order sets must:

- a. specify the circumstances under which the orders are to be carried out;
- b. specify the medical conditions to which the orders are intended to apply;
- c. be specific as to the orders that are to be carried out, including all of the relevant information that usually is given in an order; and
- d. be initially approved and reviewed every 3 years by the appropriate Medical Staff Committees.

### **6.5. Verbal/Telephone Orders**

- a. Orders dictated to a licensed person by a physician are known as verbal orders. Verbal orders may be given only in an emergency situation or when the physician is physically unable to write the orders.
- b. Orders received via telephone by a licensed person from a physician are known as telephone orders.
- c. Within the scope of their practice, Registered Nurses, Pharmacists, Clinical Dietitians, and Respiratory Therapists may accept verbal/telephone orders from a Physician, Physician Assistant and/or Nurse Practitioner.



- d. All verbal/telephone orders are repeated back to the practitioner who verifies correctness of information before the conversation is ended. Read back the frequency and/or instructions for use in the non-abbreviated format. Example: If an order is received for BID frequency, the receiver will read the order to the prescriber as “to be administered twice daily, or two times per day”.
- e. Record the verbal/telephone order immediately in the patient’s medical record or, for pharmacists, on a prescription form as appropriate.
- f. Indicate either telephone or verbal order in the written record.
- g. Verbal or telephone orders for medications must be countersigned by a physician within forty-eight (48) hours.

## **6.6 Surgical Procedures**

**6.6-1** A complete history and physical examination, in accordance with Article V Section 5.5, of the Medical Staff Bylaws and Article IX, Section 9.4-1, of these Rules and Regulations and shall be in the medical record of every patient prior to surgery.

### **6.6-2 Assistants in Surgery**

- a. Any member of the Department of Surgery holding appropriate surgical privileges shall be deemed to have “surgical assist” privileges. Members of other departments requesting surgical assisting privileges must provide evidence of current competence and appropriate professional liability insurance coverage. Requests for such privileges shall be reviewed and approved as provided in Article V of the Medical Staff Bylaws.
- b. Appropriately credentialed Advanced Practice Providers may act as surgical assistants.

## **6.7 Restraint Policy Adherence**

All Physicians, dentists, podiatrists, psychologists and APPs shall be responsible for adhering to the policies and procedures regarding the use of restraints as defined in the Alameda Health System Administrative Manual.

## **6.8 Intravenous Sedation**

Any department member wishing to administer moderate or deep sedation shall be privileged.

## **6.9 Do Not Resuscitate Orders**

- 6.9-1 All patients are to receive full cardiopulmonary resuscitation unless specific orders limiting treatment are written.
- 6.9-2 The “Do Not Resuscitate” (DNR) Order must be accompanied by usage of the appropriate form.
- 6.9-3 The decision to limit cardiopulmonary resuscitation procedures does not necessarily limit other procedures. “Do Not Resuscitate” Orders are compatible with full

intensive care unit care and palliative surgery. Resuscitative efforts for immediate surgical or anesthetic complications during palliative surgery should be discussed with the patient or surrogate decision-maker prior to surgery. The “Do Not Resuscitate Order” may be suspended during surgery by an order signed by the attending physician or designee.

## **ARTICLE VII CONSULTATIONS**

### **7.1 Consultation Requirements**

Any qualified practitioner with clinical privileges can be called for consultation within his/her area of expertise and within the limits of clinical privileges that have been granted.

#### **7.1-1 Required Consultation**

- a. Except in an emergency, consultation with a member of the Medical Staff is encouraged for cases in which, according to the judgment of the attending physician or designee, the patient is not a good medical or surgical risk;
- b. the diagnosis is obscure;
- c. there is doubt as to the best therapeutic measures to be utilized;
- d. specific skills of other practitioners may be needed;
- e. the patient exhibits severe psychiatric symptoms and is not receiving psychiatric help; or
- f. there is doubt as to the capacity of the patient to give informed consent.
- g. The Department Chair may establish additional policies regarding consultation for the Department and may require consultation:
  - 1) when he/she deems it necessary, or
  - 2) when requested by the patient or the patient’s surrogate decision maker.

## **ARTICLE VIII COVERAGE**

### **8.1 Physician Coverage**

Chairs of the Department and Division Chiefs shall be responsible to ensure that physician coverage is provided as required.

## **ARTICLE IX MEDICAL RECORDS**

### **9.1 Patient Medical Records**

Accurate Medical Records must be maintained for all patients who receive treatment at the hospital, including inpatients, outpatients and emergency patients. The Alameda Hospital medical record is defined as a hybrid health record including either electronic or paper documents and manual and electronic processes.

### **9.2 Timely Completion of the Medical Record**

9.2-1 A medical record lacking any required elements or required authentication is considered incomplete.

Medical records which are incomplete for any reason fourteen (14) days after discharge are considered delinquent. If the physician fails to complete his or her medical records within fourteen (14) days of discharge, actions including possible suspension of admitting privileges will be initiated pursuant to the policy and procedure.

### **9.3 Removal of the Medical Record**

Medical Records are the property of the Hospital. Nothing may be removed from the medical record. Records are to be maintained at all times in the Medical Record Department or in the custody of a hospital employee, Medical Staff member, or APP member at the hospital who is providing patient care. Medical records may be removed by the Custodian of Records or designee from the hospital's jurisdiction and safekeeping only in accordance with hospital policies for storage, court order, subpoena, or statute.

### **9.4 Medical Record Content**

The Medical Record shall contain:

#### **9.4-1 History and Physical Examination Report**

A comprehensive and complete general history and physical examination is required no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia service on all Hospital patients. The history and physical shall be dictated or legibly handwritten. The scope and content of the examination must be relevant to the patient's medical history and the clinical findings.

- a. The history and physical report shall be prepared by the patient's attending physician unless he or she delegates this responsibility to another physician or he or she is required by the Medical Staff Bylaws or Rules and Regulations to delegate or share this responsibility with another physician.
- b. A complete history and physical shall be recorded in the patient's medical record: within 72 hours following admission to the SNF (Title 22, 72303); and/or
- c. within forty-eight (48) hours of admission to a sub-acute bed. (Title 22, 51215.5).

#### **9.4-2 Diagnosis**

An admitting diagnosis, any changes in diagnoses occurring during hospitalization, and a discharge diagnosis must be contained in the medical record.

#### **9.4-4 Progress Notes**

Progress notes shall be entered:

- a. daily or more often when warranted by the patient's condition;
- b. at least two (2) times a week for sub-acute patients for the first four weeks and at least one (1) time a week there after; or
- c. every thirty (30) days in the Skilled Nursing facility unit or more often when warranted by the patient's condition.

#### **9.4-5 Post Operative Note**

- a. A postoperative note must be entered into the medical record immediately after surgery and include pertinent information that is necessary for care by any provider who will be attending the patient. Immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care", i.e. the Post Anesthesia Unit (PAR).

The postoperative note must include at least the following elements:

- 1) Primary surgeon and assistant(s);
  - 2) Pre- and postoperative diagnosis(s).
  - 3) Name of specific surgical procedure(s) performed.
  - 4) Description of findings and tissue removed or altered.
  - 5) Prosthetic devices or implants used, if any.
  - 6) Complications, if any.
  - 7) Estimated blood loss.
  - 8) Condition of patient postoperatively.
- b. A dictated operative report must be completed within twenty-four (24) hours of each surgery and must contain at least the information described above.

#### **9.4-6. Anesthesia Record**

An anesthesia record is required including preoperative assessment and diagnosis, if anesthesia has been administered. The pre-anesthesia record is to be completed and documented forty-eight (48) hours prior to surgery or a procedure requiring anesthesia

services and the post-anesthesia record no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services.

#### **9.4-7 Consultation Report**

In the case of a written report of the consultation, it shall be written and placed into the patient's medical record within twenty-four (24) hours of the performance of the consultation.

#### **9.4 -8 Discharge Summary**

- a. At the time of discharge, the physician responsible for the patient shall ensure that the medical record is complete, including final diagnosis.
- b. A written discharge summary form must be completed and on the medical record at the time of discharge and a discharge summary must be dictated within forty-eight (48) hours of discharge. All patients transferred from AHS to another healthcare facility must have a discharge summary sent with the patient at the time of transfer. All discharge summaries shall, at a minimum, include the following elements:
  - 1) the reason for hospitalization;
  - 2) the significant findings;
  - 3) the procedure performed and/or, treatment rendered;
  - 4) the patient's condition at the time of discharge;
  - 5) final diagnosis;
  - 6) all complications and co-morbidities;
  - 7) final disposition; and,
  - 8) the instructions given to the patient and/or surrogate decision-maker (*e.g.*, physical activity, medication, diet and follow-up care).

The discharge summary must be reviewed and authenticated by an attending physician.

#### **9.5 Access to Medical Records**

Access to all medical records of all patients may be afforded to medical staff members in good standing for bona fide study and research consistent with confidentiality of personal information concerning individual patients as prescribed in applicable state and federal law, Health System and hospital policies. Subject to applicable laws, hospital policy and the discretion of the Chief Executive Officer, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

#### **9.6 Use of Signature Stamp or Computer Key**

- 9.6-1 The medical staff permits the use of electronic signature, per the approved Medical Records Policy and Procedure.

## **9.7 Use of Symbols and Abbreviations**

**9.7-1** A list of symbols, abbreviations, acronyms and dose designations which may be used in the medical record shall be approved by the Medical Executive Committee and distributed to the Medical Staff.

**9.7-2** A list of symbols, abbreviations, acronyms and dose designations that are prohibited from use in the medical record shall be approved by the Medical Executive Committee and available to the Medical Staff.

## **9.8 Correction of the Medical Record**

In the event it is necessary to correct an entry in a medical record, the authorized person shall line out the incorrect data with a single line in ink, leaving the original writing legible. The person shall note the reason for the change, the date of striking, and sign the note. Appropriate cross- referencing shall be placed in the medical record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports must be filled in by the dictating physician at the time the report is authenticated. Any cross-outs with or without re-entries in the report should be noted, dated, and initialed. No medical record entry shall be removed from the medical record.

## **9.9 Entries in the Medical Record including Authentication, Dating, and Timing of Entries**

**9.9-1** The following health care professionals are permitted to make entries in the medical record: Medical Staff members, APPs, Nursing Staff, Dieticians, Occupational Therapists, Speech Therapists, Pharmacists, Physical Therapists, Radiology Technicians, Recreational Therapists, Respiratory Therapists, Social Workers, Hospital Clergy, and other health practitioners as designated by the Medical Staff.

**9.9-2** Each entry that is made in the medical record shall be signed by the person making the entry, dated, and timed. The date and time shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

## **ARTICLE X EMERGENCY MANAGEMENT/DISASTER**

### **10.1 Emergency Management/Disaster Plan**

All physicians shall be assigned posts either in the hospital or defined auxiliary areas during a disaster. It is their responsibility to report to their assigned stations. The Chair of the Department of Emergency Medicine and the Chief Executive Officer will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the Health System to another or evacuation from the hospital premises, the Chair of the Department of Emergency Medicine or the Emergency Department physician on duty will authorize the movement of patients in consultation with the Chief Executive Officer or designee during the disaster.

## **10.2 Credentialing in a Disaster**

Licensed Independent Practitioners who are not members of the medical staff of Alameda Hospital and who do not possess clinical privileges at the hospital, may be granted temporary or emergency privileges during a disaster pursuant to the **Medical Staff Bylaws**.

## **10.3 Plan for Mass Casualties**

The plan for the care of mass casualties shall be updated at least annually and rehearsed at least twice a year by appropriate hospital personnel.

## **10.4 Fire and Internal Disaster Drills**

Fire and internal disaster drills shall be held at least quarterly for each shift and under varied conditions.

## **10.5 In-House Medical Emergency (Non-Patients)**

### **10.5-1 Inpatient patient care areas**

Medical personnel will react as appropriate to the person's needs and, as necessary, bring him/her to the Emergency Department.

### **10.5-2 Non-patient care areas inside the Health System buildings**

The code blue team will be contacted.

## **ARTICLE XI ADVANCED PRACTICE PROVIDERS**

- 11.1** All Advanced Practice Providers shall be bound by current policies and procedures and other applicable Alameda Hospital Medical Staff Bylaws, Rules and Regulations, or Policies and Procedures.

## **ARTICLE XII PERFORMANCE IMPROVEMENT**

### **12.1 Performance Improvement Program**

- 12.1-1** The Medical Executive Committee shall, in conjunction with Hospital Administration, develop a Performance Improvement Program for patient care. The plan shall be reviewed annually and shall be subject to the approval of the Board of Trustees.

### **12.1-2 Performance Based Reappraisal**

Each member of the Medical Staff or APP Staff at the time of application for reappointment shall have a performance-based reappraisal profile. The Chair of the Department shall review the profile and use the data as a critical factor in determining the practitioner's qualifications for reappointment and for current competence and ability to perform privileges for the specific privileges or practice prerogatives requested.

## **ARTICLE XIII REQUIREMENTS FOR PROFESSIONAL LIABILITY INSURANCE**

- 13.1** Medical Staff members and APP members shall be required to provide evidence of professional liability insurance in minimum amounts of \$1,000,000 per occurrence and \$3,000,000 aggregate, evidenced in a written document which specifies amounts and dates of expiration and must name each individual practitioner covered by the policy. Hospital employees may meet this burden by providing proof of insurance by Alameda Health System.

## **ARTICLE XIV CHAIN OF COMMAND**

- 14.1** The mechanism for hospital clinical and administrative staff to communicate with the appropriate medical staff representation regarding clinical and/or administrative concerns is pursuant to the Chain of Command.

## **ARTICLE XV PRIVILEGES**

### **15.1 Introduction of a New Privilege**

New privileges to be performed at the hospital are obtained in accordance with current **Medical Staff Policy and Procedure: Introduction of a New Privilege for the Medical Staff or a New Privilege for a Specific Department or Specialty.**

### **15.2 Experimental Procedures**

If a procedure is not being performed at the hospital or elsewhere, except on an experimental basis, the applicant shall submit a proposal to the Alameda Health System Institutional Review Board to perform the procedure under the auspices of a research protocol and Section 15.1 shall apply.

## **ARTICLE XVI ON-CALL RESPONSIBILITIES**

- 16.1** Duties of practitioners on call to the Emergency Department are described in the EMTALA policies and procedures.

## **ARTICLE XVII INFECTION CONTROL**

### **17.1 Infection Control Policies and Procedures**

All physicians, dentists, podiatrists, psychologists and APPs shall be responsible for adhering to the infection control policies and procedures as defined in the Infection Control Policy and Procedure Manual for the Hospital.



## **ARTICLE XVIII COMMITTEES OF THE MEDICAL STAFF**

### **18.1 Special Committees**

Special committees, other than the below standing committees and as may be required to properly carry out the duties of the Medical Staff, shall be appointed by the President of the Medical Staff and subject to the Medical Staff Bylaws, Article XI, Section 11.1.

### **18.2 Membership**

The Chief of Staff shall determine the membership eligibility, the number of members, purposes and frequency of meetings and shall appoint the Chair in each instance. Such committees shall confine their work to the purposes for which they are appointed.

### **18.3 Standing Committees of the Medical Staff**

In addition to the committees established in the Medical Staff Bylaws, the following committees shall be established:

#### **18.3-1 Quorum**

A quorum of fifty (50) percent of the voting members shall be required for Medical Executive Committee meetings, but in no case less than five (5). For other committees, a quorum shall require the presence of at least three (3) voting members.

#### **18.3-2 Bylaws Committee**

The Bylaws Committee shall be chaired by the Vice Chief of the Medical Staff and be composed of five (5) Active Medical Staff physicians. The Chair may invite a representative from administration if there is an issue that they want to discuss.

The duties and responsibilities of the Bylaws Committee shall be to:

- a. conduct an annual review of the Medical Staff Bylaws, and Rules and Regulations; and
- b. submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices.

The Bylaws Committee shall meet as often as necessary but at least annually.

### **18.3-3 Committee on Interdisciplinary Practice (CIDP)**

The Committee on Interdisciplinary Practice shall include the Chief Executive Officer (or his/her designee), the Vice President of Patient Care Services, (or his/her designee), an equal number of Active Medical Staff physicians appointed by the Chief of Staff, two registered nurses appointed by Vice President of Patient Care Services, and the Chief Medical Officer. One or more APPs who practice at the Hospital may be appointed to serve on the CIDP by the Chief of Staff. The Chair of the CIDP shall be a physician.

The duties of the CIDP shall be to:

- a. evaluate and make recommendations regarding the need for and appropriateness of the performance of services in the hospital by APPs;
- b. evaluate and make recommendations to develop policies and procedures relevant to the formation and approval of standardized procedures;
- c. periodically review and approve all standardized procedures and clinical protocols utilized by nurses practicing in expanded roles and/or practitioners providing clinical services utilizing protocols under the supervision of a medical staff member;
- d. evaluate and make recommendations regarding the qualifications and credentials of Advanced Practice Providers who are eligible to apply for and provide services either utilizing standardized procedures or protocols; and
- e. evaluate and make recommendations regarding the qualifications and credentials of each APP applying for initial appointment and reappointment and ensure that an appraisal is performed on each Advanced Practice Provider at the time of reappointment to the Advanced Practice Provider Staff.
- f. The CIDP shall maintain a permanent record of its proceedings and shall submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The CIDP Committee shall meet at the call of its Chairperson at such intervals as the chair or the Medical Executive Committee may deem appropriate.

### **18.3-4 Ethics Committee**

The Ethics Committee shall be composed of physicians, nurses, administration, and other assigned members as may be necessary and appropriate. It should include diverse members, such as lay representatives, social workers, chaplains, other clergy, ethicists and/or an attorney.

The duties and responsibilities of the Ethics Committee shall be to:

- a. participate in the development of guidelines for consideration of cases having bioethical implications;
- b. develop and implement procedures for the review of such cases;

- c. consult with concerned parties to facilitate communication and aid bioethical conflict resolution;
- d. maintain a permanent record of its proceedings and submit periodic and timely reports of its activities and recommendations to the Medical Executive Committee.

The Ethics Committee shall meet at the call of its Chairperson at such intervals as the chair or the Medical Executive Committee may deem appropriate.

### **18.3-5 Infection Control Committee**

The Infection Control Committee shall be composed of physicians, nurses including the Infection Preventionist, administration, other representation from the Infectious Disease Service and individuals employed in a surveillance or epidemiological capacity, and other assigned members as may be necessary and appropriate.

The duties of the Infection Control Committee shall be to:

- a. develop, implement and assess appropriate quality control and performance improvement measures for the Infection Control program;
- b. develop a hospital-wide Infection Control program and maintain surveillance over the program;
- c. develop a system for reporting, identifying and analyzing the incidence and cause of healthcare associated infections, and assign responsibility for the ongoing collection and analytic review of such data, and follow-up activities;
- d. develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, body substance precaution and sanitation techniques;
- e. develop written policies defining special indications for body substance precaution;
- f. act on recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, the departments and other committees;
- g. review susceptibility of organisms specific to the hospital and its campuses; and
- h. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Infection Control Committee shall meet at least quarterly or as often as necessary at the call of its Chairperson.

### **18.3-6 Pharmacy, Therapeutics and Nutritional Care Committee (P&T)**

The Pharmacy, Therapeutics and Nutritional Care Committee shall be composed of physicians, nurses, administration (including representation from Pharmacy Services, and Nutrition Care) and other assigned members as may be necessary and appropriate.

The duties of the Pharmacy, Therapeutics and Nutritional Care Committee shall be to:

- a. develop, implement and assess appropriate quality control and performance improvement measures for professional practices and policies regarding nutrition care and the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;
- b. review and recommend to the Medical Executive Committee, relevant policy, procedures, and protocols that may be necessary for the operation of medication usage and nutritional care programs;
- c. evaluate and improve the quality of patient care provided to patients related to medication usage and nutritional care;
- d. advise the Medical Staff and Pharmacy Services on matters pertaining to the choice of available drugs;
- e. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- f. annually review and revise, as necessary, the formulary or drug list for use in the hospital;
- g. evaluate clinical data concerning new drugs or preparations requested for use in the hospital;
- h. monitor and review adverse drug reactions;
- i. to review aggregate data relevant to medication errors;
- j. to oversee clinical care related to the nutritional needs of patients; and
- k. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee

The Pharmacy, Therapeutics and Nutritional Care Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

### **18.3-7 Provider Wellbeing Committee**

The Provider Wellbeing Committee shall be composed of three (3) physician members of the Medical Staff. Members of the Provider Wellbeing Committee shall not serve as active participants on other peer review or performance improvement committees while serving on the Provider Wellbeing Committee.

The committee shall not have disciplinary function with respect to a physician's staff membership or privileges and shall not be responsible for any investigation leading to disciplinary action against staff membership or privileges/practice prerogatives.

The duties of the Provider Wellbeing Committee shall be to:

- a. provide education about physician health, addressing prevention of physical, psychiatric, or emotional illness;
- b. facilitate confidential diagnosis, treatment, and rehabilitation of physicians who suffer from potentially impairing conditions;
- c. aid the physician regaining or retaining optimal professional functioning consistent with protection of patients;
- d. educate the Medical Staff and other organizational staff about illness and impairment recognition issue-specific to physicians;
- e. allow for self-referral by physicians and referral by other organizational staff;
- f. referral of affected physicians to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions;
- g. maintenance of the confidentiality of the physician seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- h. evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a physician;
- i. monitor impaired physicians during programs of treatment and rehabilitation;
- j. report to the appropriate Medical Staff committee, at any time during diagnosis, treatment, or rehabilitation, if it is determined that the physician may be unable to safely perform the privileges he or she has been granted;
- k. monitor compliance with any mandatory drug treatment programs; and
- l. maintain only such records of its proceedings, as it deems advisable and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.
- m. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

The Provider Wellbeing Committee shall meet at the call of its Chairperson at such intervals as the chair or the Medical Executive Committee may deem appropriate.

### **18.3-8 Quality and Safety Committee**

The Quality and Safety Committee shall be composed of the Chief of Staff, the Chief of Staff-Elect and two (2) at large members of the Medical Staff appointed by the Chief of Staff. Non-physician members may include the Chief Medical Officer, Associate Chief Medical Officer, Chief Operations Officer, Vice President of Patient Care Services, Vice President of Quality, and the Director of Risk Management. The Committee shall be Co-Chaired by a medical staff member and an administrative member of the committee.

The Quality and Safety Committee has a central role in the initiation, performance and maintenance of the organization's performance improvement program. The fundamental responsibilities and duties of the Quality and Safety Committee shall be to:

- a. set priorities for organizational performance improvement activities that are designed to improve patient care processes and outcomes;
- b. develop performance improvement training programs for the organization's staff;
- c. foster communication among all departments and services;
- d. prioritize and select specific performance improvement team projects;
- e. receive aggregate reports related to performance improvement activities from Hospital support services, Medical Staff clinical function committees and all organizational performance improvement teams;
- f. receive aggregate tissue and transfusion reports;
- g. have direct oversight of the following functions:
  - 1) Improving Organizational Performance
  - 2) Leadership
- h. prepare an annual appraisal of the organization's performance improvement program; and
- i. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality and Safety Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

### **18.3-9 Quality Review Committees (QRC)**

Each department of the Medical Staff shall have a Quality Review Committee (QRC). Each department's QRC may meet separately or jointly with the QRCs of other departments at the discretion of the Chair of the Department and as approved by the Medical Executive Committee.

Each departmental QRC shall monitor the quality and appropriateness of clinical services provided by those holding clinical privileges in its department related to the divisions

represented by the QRC. When requested, the QRC shall also make recommendations to the Credentials and/or Medical Executive Committees related to specific credentialing issues. The Chair of the Department, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the Credentials and/or Medical Executive Committees.

The duties and responsibilities of the QRC's shall be to:

- a. evaluate and improve the quality of care provided to Hospital patients which may include accurate and timely medical record documentation;
- b. conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment including practitioner specific data for medication usage, medical records, transfusion review and operative and invasive care, provided by practitioners within the divisions of the departments represented by the QRC;
- c. perform peer review and/or other physician specific intensified assessments when indicated or requested by an appropriate Medical Staff committee;
- d. identify system problems requiring process improvement activity and make such recommendations to the Quality and Safety Committee;
- e. take appropriate actions when important problems in patient care or opportunities to improve patient care are identified;
- f. recommend to the Chairperson of the Department, those Medical Staff policies and procedures as may be necessary to conduct patient care and administrative Medical Staff activities;
- g. communicate the significant results of peer review and performance improvement activities to relevant practitioners;
- h. implement programs that assess compliance with clinical practice guidelines and other recognized standards of care;
- i. assume all duties and responsibilities of the departments related to quality assessment, peer review and performance improvement, which have not been otherwise assigned to the Chair of the Department and as may be described in the Bylaws and/or Rules and Regulations; and
- j. maintain a permanent record of its proceedings and submit periodic and quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality Review Committees shall meet quarterly or as often as necessary at the call of its chairperson.

### **18.3-10 Stroke Committee**

The Stroke Committee shall be composed of the Stroke Team which includes physicians, nurses, administration, other representation from the Emergency Department and Neurology Division and EMS and other assigned members as may be necessary or appropriate.

The duties of the Stroke Committee shall be to:

- a. develop, implement and assess appropriate quality control and performance improvement measures for the Stroke program;
- b. demonstrate conformity with clinical practice guidelines or evidence-based practice
- c. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality and Safety Council.

The Stroke Committee shall meet at least quarterly or as often as necessary at the call of its Chairperson.

## **ARTICLE XIX DISTRIBUTION OF THE RULES AND REGULATIONS**

### **19.1 Distribution**

Each Medical Staff member and APP shall be given a copy of these Medical Staff Rules and Regulations, which contain a general outline of policies and procedures related to the Medical Staff. Medical Staff members and APPs agree, by being granted Medical Staff membership or APP status in any capacity, to abide by these Rules and Regulations.

<b>Approved</b>	<b>Date</b>
Medical Executive Committee	11/16/18
Board of Trustees	11/29/18